AN ANALYSIS OF HEALTH CARE ADMINISTRATION IN HIMACHAL PRADESH: A STUDY OF CHAMBA AND KANGRA DISTRICTS OF THE STATE

A SYNOPSIS

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INTRODUCTION:

Health is a very significant and vital factor to identify that a country is prosperous and happy. Promotion of health is essential to national progress.[1] Nothing could be greater significance than the health of the people in terms of resources for socio-economic development[2]. In other words, it can be stated that the health is a base or yardstick on which a country's progress or deterioration can be measured. The promotion and protection of the health of the people is essential to sustained economic and social development. It is contributes to a better quality of life and to world peace.

In recent years, Governments all over the world have come to accept health as a public responsibility. In the developing countries like India, the Governments regulate and maintain health standards, provide preventive and curative services. These efforts represent man's struggle for survival against the onslaughts of nature and create the greatest unmet challenge for health system in most developing countries. The common concern for human health and freedom from disease provides a purposeful focal point around which international co-operation has developed over the years.

The United Nations Organization (UNO) to keep in mind the importance of public health has been set up a separate institute knows as World Health Organization (WHO). The main aim of World Health Organization is to take care of the public health by providing health services and necessary facilities being a right of the people.[3]

The growth of civilization in this century and great developments in medicine have stressed the significance of socialized health, i.e., provision of health facilities to every individual in a society. Secondly, there was also marked increase in the international effort in the last 65 years to combat problems of communicable diseases and medical care starting from the Health Organization of League of National to the Present World Health Organization.

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1 G., Rameshwaram, "Medical and Health Administration in Rural India" Ashish Publishing House, New Delhi, 1989,

2 S.L Goel., "Public Health Policy and Administration," Deep & Deep Publication Pvt. Ltd., New Delhi, 2005.

3 B.S. Pimple, "Rural Health Administration in Maharashtra" IIJRJ, April 2012, ISSN-0975-3486, vol. 3.

The 30th World Health Assembly in 1977 launched a movement Health for All by 2000 AD, aimed at attaining a minimum level of health which would permit all people in the world to lead a socially and economically productive.[4] Following this path-breaking declaration, came the international conference on Primary Health Care held at Alma-Ata, USSR, in 1978, which issued another declaration exhorting that Primary Health Care was key in attaining Health for all by 2000AD.[5]

The 65th World Health Assembly of the WHO adopted the concept of Universal Health Coverage (UHC) as a citizen's right in 2005, which implies, inter alia, that reforms in health sector must aim at improving the public hospital system, raising the quality of care, creating benchmarks, and introducing transparent regulatory processes. Acknowledging this the Planning Commission established the High Level Expert Group (HLEG) to address, inter alia, issues of rising costs of private care and insurance payment that new can afford. The HLEG has suggested comprehensive plan to attain UHC by 2020 and to help every citizen access to a national health package of essential primary, secondary and tertiary care, both inpatient and outpatient. Services must be tax funded and cashless at delivery. User fees are to be abolished since they are inefficient, inadequate and iniquitous. India has already pledged more funded by increasing budgetary allocation and raising funds from other sources.[6]

CONCEPTUAL FRAME-WORK:

Health

The World Health Organization define health as " a state of complete physical, mental, socio and spiritual well being and not merely an absence of disease or infirmity."[7] Wilson defining health includes "preventing diseases, prolonging life, promoting physical and efficiency."[8]

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4 V. Shreekant, Khandewale., "Health Administration and the Weaker Section in an Indian Metropolis" Devika Publications, Delhi, 1996, p. 2.

5 Ibid…

6 Dr. Amrit Patel "Improving Performance of Rural Health Services" Kurukshetra, August, 2012, p. 15.

7 S.L. Goel. "Public Health Policy and Administration," Deep & Deep Publication Pvt. Ltd., New Delhi, 2005, p. 19.

8 V. Shreekant, Khandewale, "Health Administration and the Weaker Section in an Indian Metropolis" Devika Publications, Delhi, 1996, p. 18.

Thus, good health is a synthesis of physical, mental and social well-being. As stated in the First Five Year Plan, "Health is a positive state of well being in which in harmonious development of mental and physical capacities of the individuals lead to the enjoyment of a rich and full life… It implies adjustment of the individuals to his total environment- physical and social."[9]

Administration

Public Administration is an aspect of larger field of administration. The English word administer is derived from a combination of two words, 'ad' + 'ministrare' which means to save, to direct, to control and to manage affairs. In its literal sense 'administration' simply means management of affairs.[10] Pfiffiner and Presthus defined administration as organization and direction of human material resources to achieve desire ends.[11]

Health Administration

It is a branch of Public Administration which deals with the matters relating to the promotion of health, preventive services, medical care, rehabilitation, the delivery of health services, the development of health manpower and the medical education and training.[12]

Health Care Administration

Health care administration focuses on designing and maintaining systems of health care that improve the health of individuals and reduce health access and health care inequities. Health care administrators work to assure community access to the health care system and access to appropriate and necessary services for all people, especially those who are medically vulnerable. They continuously assess health care needs and resources and work to balance the two. Health care administrators may oversee large health systems or individual departments. They may work in large hospitals or small medically-oriented facilities such as nursing homes or

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9 S.L. Goel, "Public Health Policy and Administration," Deep & Deep Publication Pvt. Ltd., New Delhi, 2005, p. 19.

10 S.P. Naidu, "Public Administration: Concepts and Theories" New Age International Publishers, p.3.

11 S.L. Goel, "Public Health Policy and Administration," Deep & Deep Publication Pvt. Ltd., New Delhi, 2005, p. 19.

12 Ibid.

hospice care. Health care systems around the world are changing and developing at rapid rates. Administrators need to stay in touch with these changes and work to promote changes that benefit the members of the communities in which they live and work.

HEALTH CARE ADMINISTRATION IN INDIA:

The experience and concern in health development and primary health care in India date back to the Vedic period, in the Indus-Valley Civilization as far back as 3000 B.C., one finds evidence of well-developed environmental sanitation programmes such as underground drains, public baths in the cities etc. 'Arogya' or 'health' was given high priority in daily life and this concept of health include physical, mental, social and spiritual well being. This cherished value regarding health is also enshrined in an ancient **Sanskrit** verse, Sarve Santu Niramayaha', which means 'Let all be free from disease/let all be healthy', and which was often used to express good wishes. The life style was conducive to health promotion and in the advocated daily activities of life called 'Dina Charya' the following essentials of health care were emphasized: health education, personal hygiene and habits, exercise, dietary practices, food, sanitation, environmental sanitation, code of conduct and self-discipline, civic and spiritual values, treatment of minor ailments and injuries etc. In Ayurveda i.e**.** the 'Science of Life', one finds even in 1400 B.C. emphasis on health promotion and health education. Unfortunately, for various reasons and particularly because of the onslaught of series of foreign aggressions and regimes leading to disruption of pre-existing health services as a part of social and cultural interactions and exchanges, the great era was lost to darkness. Ayurveda not only failed to develop, but in fact, it languished because of want of adequate state patronage and recognition.[13]

During the middle of the 18th century, the British Government in India established medical services which were primarily meant for the benefit of the British nationals, armed forces and a few privileged civil servants. But the vast majority of the native population was denied access to the Western medicine.

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[13] Somnath, Roy, "Primary Health Care In India" Health and Population-Perspective & Issues, 1985, p. 136.

Indigenous systems of medicine were totally neglected and allowed to languish. Services which were available in general hospitals located in big cities and commercial centers were largely curative for the care of the sick and injured. Later on, some preventive measures were provided for the control of epidemics, and dispensaries were opened in some remote villages. Provincial health Departments were established in 1919. But neither health planning nor medical education was related to the health needs of the people. This strong Western bias was largely responsible for blind adoption of sophisticated modern medicine for a few, neglecting the vital interests of the vast majority.[14]

Health is a vital indicator of human development. Health standards in India have improved considerably since independence. The concerted efforts of the government and other agencies engaged in expanding that health infrastructure have paid off, as evidenced by the improvement in some of health indicators. Longevity has more than doubled since independence, infant mortality rate has fallen, malaria has been contained, small pox and guinea worn have been completely eradicated and leprosy and polio are nearing elimination. The Government of India have made deeper inroad into rural areas with focused schemes like the National Rural Health Mission and have been even started a scheme for health insurance for the poor population.

In India, Right to Health is part of Right to Life enshrined under Article 21, and has been interpreted in this way in several ruling of the supreme Court of India. This means is that it is the states' primary responsibility to ensure primary health care in a socially just and equitable environment.[15]

The Constitution of India makes provision in the state list and concurrent list to provide health to all the people in the country. Public health and sanitation, hospitals and dispensaries are one the state list and population control and family welfare are in the concurrent list of the Indian Constitutions. Great progress has been made since independence in the health status of the population this is reflected in the improvement in some

[14] Ibid.
[15] Kurukshetra, Journal on Rural Development, February, 2010.

health indicators under the cumulative impact of various measures and a host of national programs for livelihood, nutrition and shelter, life expectance rose[16]. As on 1st March, 2011 India's population stood at 1.21 billion comprising of 623.72 million (51.54%) males and 586.46 million (48.46%) females. India, which accounts for world's 17.5 percent population, is the second most populous country in the world next only to China (19.4%). In 1951, the population of India was around 381 million. In absolute terms, the population of India has increased by more than 181 million during the decade 2001-2011. Of the 121 crore Indians, 83.3 crore (68.84%) live in rural areas while 37.7 crore (31.16%) live in urban areas, as per the Census of India's 2011.

The Average Annual Exponential Growth Rate (AAEGR) for 2001-2011 dipped sharply to 1.64 percent per annum from 1.97% in 1991-2001 and 2.14 percent during 1981-91.

Post independence the sex ratio (Number of females per 1000 males) in India had recorded decline till 1991. Sex ratio in India has since shown some improvement. It has gone up from 927 females per 1000 males in 1991 census to 933 females per 1000 males in 2001 census and to 940 females per 1000 males in 2011 Census of India.

The Life Expectancy which was 49.7 years during 1970- 75 increased to the level of 63.0 years in 2000-04 further improved and stood at 63.5 years during 2002-06. This has revealed decrease in death rate and the better improvement of quality health services in India. However, there are inter-state, male-female and rural-urban differences in life expectancy at birth due to low literacy, differential income levels and socio-economic conditions and beliefs. In Kerala, a person at birth is expected to live for 74 years while in states like Bihar, Assam, Madhya Pradesh, Uttar Pradesh, etc, the expectancy is in the range of 58-61 years. The Crude Birth Rate (CBR) declined from 29.5 per 1000 population in the 1991 to 22.1 in 2010. The CBR is higher (23.7) in rural areas as compared to urban areas (18.0). However, there are inter-state and rural-urban differences are quite pertinent. Uttar Pradesh recorded the highest

[16] Dr. Amrit Patel "Improving Performance of Rural Health Services" Kurukshetra, August, 2012, p. 15.

CBR (28.3) and Goa the lowest (13.2). Assam (23.2), Bihar (28.1), Haryana (22.3), Chhattisgarh (25.3), Jharkhand (25.3), Madhya Pradesh (27.3), Rajasthan (26.7) and Uttar Pradesh (28.3) recorded higher CBR as compared to the national average. Among the Smaller States / UTs, D&N Haveli (26.6) and Meghalaya (24.5) recorded higher CBR as compared to the national average. Kerala (14.8) among the bigger States and Goa (13.2) among the smaller states /UTs recorded the lowest CBR during 2010.

The Crude Death Rate (CDR) which was 25.1 per 1000 population in 1951 came down to 9.8 in 1991 and further declined to 7.4 in 2007. During 2008 it remained at 7.4 but came down to 7.3 in 2009. During 2010 the CDR further declined to 7.2. The CDR is higher in rural areas (7.7) as compared to urban areas (5.8). The CDR is higher as compared to national average in respect of Andhra Pradesh ((7.6), Assam (8.2), Chhattisgarh (8.0), Madhya Pradesh (8.3), Odisha (8.6), Tamil Nadu(7.6), Uttar Pradesh (8.1), Puducherry (7.4) and Meghalaya (7.9). Delhi (4.2) among the bigger States and Nagaland (3.6) among the smaller states /UTs recorded the lowest CDR during 2010. Maternal Mortality Ratio (MMR) has reduced from 254 per 100000 live births in 2004-06 to 212 per 100000 live births in 2007-09 (SRS), a reduction of 42 points over a three year period or 14 points per year on an average. In the four southern states, Kerala and Tamil Nadu have already achieved the goal of a MMR of 100 per 100000 live births but, within the group, Karnataka lags significantly behind with a MMR of 178 per 100000 live births and at current rate of decline would only reach to about 130 per 100000 live births in the year 2012.

The Infant Mortality Rate (IMR), 47 per 1000 live births in 2010 as compared to 50 in 2009 at National Level. The IMR has shown a steady decline from 129 deaths per 1000 live births in 1971 to the current level. The IMR is higher in respect of Female (49) as compared to Male (46). IMR is also higher in rural areas (51 per 1000 live births) as compared to urban areas (31 per 1000 live births) during 2010. The IMR varied very widely across the states; Kerala with an IMR of 13 is the best performing state among the bigger States in the country.

Under-five Mortality Rate (U5MR) is measured in terms of death of number of children (under five years of age) taking place per 1000 live births. The U5 MR declined from 69 in 2008 to 59 in 2010. However, the Male–Female and Rural-Urban differential persists. Kerala with U5MR of 15 in 2010 is the best performing state in the country.

India's Total Fertility Rate (TFR) is at 2.5 and the target is to achieve Replacement level of Fertility of 2.1 by 2012. While 21 States and UTs (Andaman & Nicobar Islands, Goa, Puducherry, Manipur, Tamil Nadu, Kerala, Tripura, Chandigarh, Andhra Pradesh, Himachal Pradesh, Jammu & Kashmir, West Bengal, Punjab, Delhi Maharashtra, Daman & Diu, Karnataka, Mizoram, Nagaland, Sikkim and Lakshadweep) have already achieved the replacement level, 8 States have TFR between 2.1 and 3.0. Six States/UT (Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh., Meghalaya, and D&N Haveli) have TFR more than 3.0.[17]

HEALTH CARE ADMINISTRATION IN HIMACHAL PRADESH:

Himachal Pradesh is a hilly and mountainous state, having difficult terrain and topography. Thus, it has maintained a marked and steady overall progress in all the socio-economic and political sectors ever since it came into being in 1948. Health and education are the two important services where the state is doing quite well. A new era in health services started when Himachal attained statehood in 1971.[18]

90% population of Himachal Pradesh settled in rural areas. The state Govt. has ensured that health services for effective prevention and treatment intervention care accessible to people and applied efficiently. Health and Family Welfare department is providing services which include curative, prevention, promoting and rehabilitative services. To providing better health services to the people the government is strengthening the existing infrastructure.[19]

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17 Ministry of Health and Family Welfare, Government of India, Annual Report to the people on Health, December, 2011

18 Jag Mohan, Balokhara, "The Wonderland of Himachal Pradesh" H.G. Publication, New Delhi, 2013.

19 Economic survey of Himachal Pradesh 2012-13.

Himachal Pradesh implemented of the National Health Policy and various National Health Programmes like National Rural Health Mission (NRHM), Reproductive and Child Health (RCH), Revised National Tuberculosis Control Programme (RNTCP), AIDS Control, National Blindness Control Programme, National Leprosy Eradication Programme (NLEP), Cancer Control Project, National Mental Health Programme and Health Care Component of the Employee's State Insurance Corporation (ESIC).[20]

Himachal Pradesh has been included among 18 State of the country for the implementation of National Rural Health Mission (NRHM). NRHM is a landmark for providing accessible and affordable health care to all citizens living in rural areas particularly to the poorer and weaker sections. It lays stress on reducing maternal and infant mortality, universal access to public health services, prevention and control of communicable and non-communicable disease, ensuring population stabilization, maintaining gender balance, revitalization of local health traditions and promotion of healthy life styles. Under the overall umbrella of NRHM a number of programmes especially the Reproductive and Child Health Programme (RCH-II), Immunization Programme, Janani Surksha Yojna (JSY) and Disease Control Programme has been included. The mission focuses on decentralized implementation of the activities and funneling of funds, it sets the stage for Distt. Management of Health and active community participation in the implementation of health programmes. The Himachal Pradesh Govt. has already constituted the State and District Health Mission and grass-root activities have been started with zeal and zest. All the CHCs would be converted into First Referral Units under the programme in a phased manner. Similarly, 50% of the PHCs in the State would be providing 24 hours services by the end of the programme. The programme also focuses on convergence with IPH, Rural Development and Panchayati Raj, Ayurveda and Social Justice and Empowerment Departments.[21]

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[20] Health and Family Welfare Department of Himachal Pradesh, report, December, 2012.
[21] Ibid.,

REVIEW OF LITERATURE:

Research takes advantage of the knowledge which has accumulated in the past as a result of constant human behavior. It can never be undertaken in isolation of the work that has already been done on the problems which are directly or indirectly related to the study proposed by the researcher. A careful review of the research journals, books, dissertations, thesis and other information on the problem to be investigated is one of the important steps in the planning of any research study. A review of the related literature must precede any well planned research study.

The review of related literature enables the researcher to define the limits of the field. It helps the researcher to delimit and define problem. In this the researcher can select these areas in which positive findings are very likely to result and his endeavours' would be likely to add to the knowledge in a meaningful way. The survey of related studies implies reading and analyzing the researches already done and reported in dissertations, thesis, journals, abstract or in any other published form. The related studies thus represent the collective body of the prior work also referred to as research literature. The survey of related studies already conducted in the field enables the researcher to acquaint with the present state of knowledge. Some reviews related to the proposed study:

Goel (1980)[22] his book entitled "Health Care Administration: Ecology, Principle and Modern Trends" deals with the nature, scope, role of health care administration and its relationship with socio- economic development. It examines the challenges of health and health care administration with special reference to South-East Asia. The role of voluntary health agencies has been emphasized and suggestions have been made for their effective's utilization in delivery of health services.

Goel (1980)[23] analyses another book entitled "Health care Administration: Policy-making and Planning" the process of policy-making and planning for health care system and examines the role of different agencies

[22] S.L. Goel, "Health Care Administration: Ecology, Principles, Modern Trends." Sterling Publishes Pvt. Ltd. New Delhi, 1980

[23] S.L. Goel "Health Care Administration: Policy-making and planning." Sterling Publishes Pvt. Ltd. New Delhi, 1980

and stages in the formulation of health policy and plans. It has been rightly said that among the elements relating to the development administration, policy –making and planning are most significant. He points out for improving the health system in any country needs different categories of health personnel to personnel to implement health programmers.

Goel (1981)[24] reveals the organizational and administration aspects of health care administrations in this book entitled "Health care Administration: Level and Aspects." It analyses the role of various international health agencies. The problem of environmental sanitation is also discussed.

Goel (1984)[25] his book entitled "Public Health Administration" deals with role of health care administration and its relation with socio,-economic development. In this book the author has emphasized on the equal distribution of resources. It has made a modest contribution to the existing literature on this expanding field.

Rameshwaram (1989)[26] in this book covers the most important expects of medical and health administration. Author throws light on National Health Policy Administration set-up both indigenous medical system and allopathic health facility in India. Author in his book also deals of organization and working of medical and health care institutions in rural areas along with health care problems of the rural peoples. The main objective of the study was to evaluate the national health policy and examine the organization and working of allopathic medical and health care institution civil hospital and primary health centres.

Rao (1992)[27] in this book entitled," Health and Hospital Administration in India," published in 1992. This deals with critical discussion on the problems of organizational and administrative process of health and hospital institutions in India. This book is divided in two parts.

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[24] S.L. Goel "Health care Administration: Levels and Aspects." Sterling Publisher Pvt. Ltd. New Delhi, 1981

[25] S.L. Goel "Public Health Administration," Sterling Publishers Pvt. Ltd. New Delhi, 1984

[26] G., Rameshwaram, "Medical and Health Administration in Rural India" Ashish Publishing House, New Delhi, 1989.

[27] M. Sankara, Rao, "Health and Hospital Administration in India" Deep & Deep Publications Pvt. Ltd., New Dehi, 1990.

Part-I (Health Administration) consisted of eight chapters that deals history and evaluation of health organization and administration in India as well as future management role in the organization.

Part-II (Hospital Administration, consists of twelve chapters, which deals with history with evolution of hospital system and administration in India as well as future regional planning of hospital services.

Khandewale (1996)[28] analyzed the health care services in urbanization in his book, 'Health Administration and the Weaker Sections in An Indian Metropolis." He has beautifully explained it in his research work during his Ph.D. the main focus of the study is on Delhi- The Indian capital, and the organization and functioning of its municipal health administration. In this book, author described the knowledge about perception, provision, limitation and utilization at municipal health facilities by the economically weaker sections of the society.

Another a field study has been carried out of various categories of health personnel to have their view on various aspect of municipal personnel administration and also their opinion about facilities provided by the corporation to the patient and to them as well. The author has been also analyzed the growth of the metropolis structure of the various local bodies of the Delhi city.

The author explains some important issues concerning the health care services problem faced by weaker section of the metropolis. Lastly, author has been attempt to the study of evolution, formulation of health policy in order to the understanding operational aspects of health institutes and delivery of health care services.

Chawla (1999)[29] made an attempt to study the "Primary Health Care Administration in Himachal Pradesh" it was concluded that A) the high rate of population growth continues to have an adverse effect on health of its people and the quality of their lives. B) Despite improved economy and social progress in the field of education and other areas, the State of Himachal

[28] V. Shreekant, Khandewale, "Health Administration and the Weaker Section in an Indian Metropolis" Devika Publications, Delhi, 1996.

[29] Dr. Sudesh Kumar Chawla "Primary Health Care Administration in Himachal Pradesh" Punjab University, Chandigarh, 1999.

Pradesh is still faced with some negative aspects of the health picture. C) The study has indicated that the Health Minister does interfere in day-to-day administration of policies and programmes pertaining to Health and Family Welfare. Most of the pressure on the Heath Minister, which consumes most of his time and energy, rises from approaches made by various people directly for grant to permits and licenses. D) Further, it is found that the Health Secretary (IAS) and the Head of the Health Department (a specialist) do not smoothly in the running of the Department. Of late, however there has been a growing tendency on the part of Secretary to regard himself as government and to treat the Head of the Department at subordinate. E) Further, it is revealed that most powers, both in financial and administrative sphere, belong to the Secretary. In many cases, this has largely hampered the functioning of health programmes and schemes. F) To supply of medicines and equipment was inadequate in 66 percent of the selected health centres due to the paucity of resources. G) Communicable diseases take a heavy toll of human life, especially in rural areas. The study revealed that disease control programmes were implemented satisfactorily.

Kumar (2002)[30] made an attempt to study the "Organization and Working of Health and Family Welfare Administration in Himachal Pradesh: A Critical Analysis." The researcher has come to light some findings of his research work: 1) No single unit/section to think, implement and analyze reform in health administration at the state level. A high-powered body/committee should be created to take care of all the reform in Health Administration. 2) State Health Department has been often labeled as the den of corruption. 3) The relationship between the Secretariat and Directorate is based on formal procedures where decisions are taken based on justification rather than rationalities. Medical education research and training to the health personnel generally have urban shift and is stereotyped. Inadequate Health Management Information System and its updating at the State level. 4) District supervision is quite inadequate. Reason being only two officials at district has to supervise the entire health care administration. Presently, there is needed

[30] Dr. Ravinder Kumar "Organization and Working of Health and Family Welfare Administration In Himachal Pradesh: A Critical Analysis" Punjab University, Chandigarh, 2002.

to make the supervision more effective by adding some supervisory committee at the district level. 5) Health care administration in the district is working in isolation. There is no involvement of such groups or a special group which matters are making the health care programmes success. 6) Lack of coordination for promotion of health and family welfare work within the districts. 7) There is mis-matching of health personnel and large number of vacant positions affects the effeteness and efficiency of health care services. 8) Family welfare programmes are forced on the people rather than their acceptance by the people. Family planning programmes suffer from inadequate services and supplies. There is lack of competence and commitment on the part of key functionary in the Family Welfare Programmes. Ineffective legislation, inadequate incentives and partial awareness back up these Family Welfare Programmes.

Qudeer (2002)[31] examined the National Health Policy 2001 and suggested he stated that the investment share of the union Government should go up to 25% from the present level 20% of the total health expenditure. It should include greater investment by the states as well, whose expenditure has gone down from 7% to 5% of their budgets. The commitments of 1983 policy for creating well worked out referral system have to be designed in favour of commercialization and expansion of the private markets in health. National Health Policy (NHP) 2001, has a protective approach toward favouring the elite of the private sector, because, it is seen as an instrument of earning hard currency by encouraging the supply of services to patients of foreign origin on payment, which on set of era of globalization and new economic policies, this is the most central gain with exclusion of health of the marginalized and as such directly hitting the poor.

He suggested that, primary, secondary and tertiary care should be ensured for underprivileged. This is possible through a National Health Insurance, system, where risk pooling and collective responsibility for the less privileged is honored. The health taxation policy with substantial inputs from the state alone can resolve the present criers of health care.

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[31] Imrana, Qudeer, "Draft National Policy, 2001, Debt Payment and Devaluing Elements of Public Health," "Economic and Political Weekly," January 2001, p.15.S

Vasudeva (2002)[32] studied the issue of the public health and poverty problem in South-Asia countries namely consisting Sri Lanka, Bangladesh, Pakistan, Nepal and India. She stated that Nepal is among the poorest countries and its Human Development Index (HDI) and literacy rate are low. Pakistan Gross Domestic production (GDP) as per capita income is the highest in South-Asia but HDI is low, where as India presents a picture of diversity, where each province has a unique experience while its GDP is less the Pakistan and the proportion of the population below the poverty line is higher but its social sector indicators are comparatively better.

Nayar (2004)[33] stressed that the Health is one of the goods of life to which man has a right, where every this concept prevails; the logical sequence is to make all measure for the protection and restoration of health accessible to all and free of charge. Medical like education is then no longer a trade it because a public function. He referred that many studies on the health services system in the country, especially on primary care institutions reveal the over whelming preferences of people for government services.

Goel (2005)[34] in his book entitled "Public Health Policy and Administration" published in 2005. This book deals with the nature, scope, role of health care administration and its relationship with socio-economic development. It analyses the challenges of health and hospital care administration in the context of developing countries with special reference to South-East Asia. The problem of population explosion has been engaging the attention of policy-makers, planners and administrators since the last fine decade without much success. The population policy and the family planning programmes to make its success time bound. A careful study of quantitative elements indicate that they interact continuously, while quantitative performance is necessary on the basis of effective performance, it is in itself of little value unless a high qualitative standard is achieved. When the qualitative shortcomings are glaring, it is easy to isolate them and pick them out. But often they elude an objective assessment. The author has, however,

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32 Uma, Vasudeva "IMF and Public Health" The Tribune January,20, 2002, p.5.

33 K.R. Nayar "Health in the Ninth Plan" Economic and Political Weakly, Feb.2004. pp. 455-457.

34 S.L. Goel, "Public Health Policy and Administration," Deep & Deep Publication Pvt. Ltd., New Delhi, 2005.

made an enquiry into the quality and adequacy of arrangements made for motivating the family planning programmes as a way of life.

It also analyses the process of policy-making and planning for health care administration. It discusses the role of different agencies and stages in the formation of health policy and plan. It has been rightly said that among the elements relating to the development of administration, policy-making and planning are the most important and yet the least developed. The formulation of realistic and scientific health policy and pans based upon our realistic assessment and understanding of our health needs and problem will go a long way towards the best utilization our resources. Besides, the issues and problems connected with the education and administration of nursing have been dealt with.

It further analyses the organizational and administrative aspects of health care administration. It examine the role UN system- Who, UNICEF, etc. " The International Co-operation which is implicit in the very concept of WHO is the alchemy which has translated the good will and good sense of nations into action directed to making this world a healthier and more decent place for all mankind." The issues and problems concerned with multi-lateral technical assistance provided through these agencies has been examined quantitatively and qualitatively to assess their impact on the health status of the people inhabiting this world. After this, the role of health administration at the Federal/Union level has been assessed in order to improve its administrative set-up to sub serve the needs of the society. The real authority to deals with health care is vested in regional/state governments. It needs innovative measures to improve the functioning of health administration at the States level. The most serious problem is of adequate coverage of health services in the fields for which have introduced the machinery of PHCs, Subsidiary Health Centres, Sub-centres and Community Health Workers Scheme. The success of this structural pyramid depends upon the efficiency of PHCs which has been analyzed in depth. In this book, the newly introduced Community Health Workers Schemes has also been examined in light of the International Conference on Primary Health Care, Alma-Ata, USSR (6-12

September 1978) prevalent in different parts of World and how this experience can be useful to India.

Bajpai, Sachs & Dholakia (2009)[35] made an attempt to the study on "Improving Access, Service Delivery and Efficiency of Public Health in Rural India: Mid Term Evaluation of The National Rural Health Mission." This Study conducted in three states Madhya Pradesh (MP), Rajasthan (RJ) and Utter Pradesh in India on the basis of NHRM's high-focus states. There was other several key feature of the study of including NHRM and to study other programmes like as role of Accredited Social Health Activist (ASHA), role of Panchayati Raj Institutions, health infrastructure and human resources at Health Centers situated in the rural areas.

Goel (2010)[36] in his book entitled "Management Techniques and Good Governance" has been divided into 19 chapters. First chapter deals with nature, scope and role of governance in the delivery of health to services people efficiently. Second chapter focuses on the role of health in socio-economic development as health is wealth. Chapters 3, 4 and 5 examine the role of planning, decision-making supervision in delivery of health services. Chapters 6, 7, and 8 discuss communication, co-ordination, control, headquarters, field relation and organization analysis as instruments of promoting good health. Chapters 9, 10 and 11 deals with method study works, measurement, management of interpersonal relations and motivation and morale to enhance the organizational. Chapters 12, 13 and 14 examine time management, human-resource development and organizational development which are important for enhancing the capability and capacity of health personnel. Chapters 15, 6 and 17 deals with management of employees health, management techniques for inculcating aesthetic since among health and medical personnel as well as selfless services for building health system on truth, beauty and goodness. Chapters 18 and 19 deals with techniques to promote human excellence among health experts and modernizing health and medical care system.

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[35] Nirupam Bajpai, Jeffrey D. Sachs and Ravindra H. Dholakia "Improving Access, Service Delivery and Efficiency of Public Health in Rural India: Mid Term Evaluation of The National Rural Health Mission." CGSD Working Paper No. 37, October 2009

[36] S.L. Goel, "Management Techniques and Good Governance in Health Care System and Hospital Administration" Deep & Deep Publications Pvt. Ltd., New Dehi, 2010.

Tondon & Mehra (2011)[37] have critically examines various models of public health care in different countries in their Article " Towards Health For All: Some Suggestions to Policy Makers ." in addition it examines efforts of making not only curative health care but also preventive care, as practiced in India. Based on the a new policy framework has been suggested and covering four areas- (a) participation of beneficiaries in the production and consumption of health care in various forms based on ability to pay for the same; (b) increase the ratio of availability of pre-requisites for health care, both curative and preventive by increasing supply of trained medical staff and hospital beds; (c) encourage public-private partnership to achieve the provisioning of pre-requisites of health care; and (d) changing the social fabric where insistence on private practice of the doctors is dissuaded and institutional practice is persuaded.

Pimple (2012)[38] this article titled "Rural Health Administration in Maharashtra." In this article the author has analyzed the rural health administration, health policy and health infrastructure of the rural areas in the states of Maharashtra. The author also mentioned the current need for rural areas is medical and paramedical manpower.

Qudeer (2013)[39] has analysis the health care and technology within the shifts in capitalist evolution from welfare to neoliberal development and examines why the concept of comprehensive Primary Health Care has been distorted by the market to varying extents globally. Its focus is on India's planning process where the thrust is to transform health services into commodities and tools of extraction of profit to which all level of health care are subordinated. Since the 1990,s all plans, official planning committees and legislations are meant to mould services in this direction. Instead of an integrated health service with primary health care getting support from the secondary and tertiary, the current thrust of the planning process has been to fragment health services into independent components - Universal Health

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37 B. Tondon, & R. Mehra,, "Towards Health For All: Some Suggestions to Policy Makers" Quarterly Journal of The Indian Institute of Public Administration, January-March, 2011, Vol. LVII, pp. 66-81.

38 Dr. B.S. Pimple "Rural Health Administration In Maharashtra" International Indexed & Referred Research Journal, Vol. 3. April. 2012.

39 Imrana, Qadeer, "Universal Health Care: The Trajon House of Neoliberal Policies" Social Change Journal, Volume 43, Number 2, June 2013, pp. 149-164.

Care, tertiary care and National Rural Health Mission- in the name of providing rural and urban health services. In each of these strategies, public-private partnership, commercialization and appropriation of the public resources are the dominant trends. UHC thus no more remains the state- led integrated and inclusive services but a Trojan horse of the neoliberal strategy.

D'souza and Leelavathi (2013)[40] has attempt to the public health services in Karnataka and review the health profile of the state. In this article they attempt they examine the gains and gaps in the public health delivery system against the background oh States Integrated Health Policy 2004. They also examine the current health statistics, while also compared with other Southern States, to ascertain the claim, aims and vision articulated in the Integrated Health Policy 2004. They also suggest measured to harvest more gains in the field of public health services.

Chaudhuri (2014)[41] has published an article "Ailing Social Sector and Political Apathy" in the newspaper. The author criticizes the delivery of health care services in many perspectives in India. Author touched many points where delivery of health services are so many poor like as., reproduction health, malnutrition and vaccination, misuse of financial schemes, role of Medical Council of India (MCI), equitable health care and insufficient of health budget.

[40] D, souza Prakash Alwyn & Lleelavathi. D.S. "Public Health Services in Karnataka: A Comparsion with Southern States" Social-Action: A Quarterly Review of Social Trend." Vol-63, July-September-2013, pp. 270-90.

[41] Mohuya Chaudhari, "Ailing Social Sector and Political Apathy" The Tribune, Chandigarh, March, 27, 2014, p. 11.

STATEMENT OF THE PROBLEM:

Good Health is a major requirement for the development of a nation. Nothing is a greater important the health of its citizens. Yet despite all this realization, the 75 percent of health infrastructure is concentrated in cities where only 31 percent of population lives and 69 percent of Country's population settled in rural areas is devoid of proper health care services.

- ❖ Population explosion.
- ❖ The rural health centres are poorly located, making access difficult.
- ❖ The capacity of rural health workers to provide health care services which are most frequently sought by villagers is strictly limited by public health policy and by the scope of the workers training.
- ❖ The range of medicines available at most rural health centres is narrow, further limiting the range of medical care services.
- ❖ The importance of disease prevention and health promotion services, the major responsibilities or rural health workers, not well appreciated by rural villagers.
- ❖ Post inter–action at government health facilities some-times subjected patients to long waits, discourtesies, and other inconveniences making them reticent to seek care again, or to recommend the facilities to friends.
- ❖ Inadequate coverage of population in need of services by the existing health services delivery infra-structure in rural areas.
- ❖ Inadequate community organization for health, social and economic development activities.
- ❖ Highly centralized management and administration system.

Himachal Pradesh is a hilly and mountainous state, having difficult terrain and topography. Thus, problems of this state are more complicated

than plain areas of the other states of the country. It has not sufficient means of transportation and communication and the population is scattered in remote areas. People have to travel a long distance on foot to reach the nearest health care centre. Health personnel are allocated unmanageable area both in terms of terrain and population.

In spite, of drastic development in the field of science and technology in the last few years, the achievement of health care services is not so much satisfactory in rural and remote areas in the state.

Therefore, it is desired to study the main problems of health administration, and then try to find out what is proper mechanism for solving all the problems in Health Care Administration.

SIGNIFICANCE OF THE STUDY:

Health Care Administration in Himachal Pradesh has been proposed under this study. After Independence it underwent a great change. India made lot of efforts for improving health status of weaker sections as well as rural people. Despite the formation of committees and policies, implementation of various plans and programmes for the better health care services of the rural people, but there is no satisfying improvement in their health status.

Keeping in view the above facts, the present study aims to access the overall working of health care administration in Himachal Pradesh with special reference to its coverage, quality of services and infrastructure. The study will try to find out the reason for dissatisfaction among the patients.

In India, several studies have been conducted in this particular field of health and health administration, but no such study has been done in this field in Himachal Pradesh. It is because of this need the researcher has be selected this field. The present study will be some unique feature so as differ from others studies conducted in India and fill up research gap existing present.

OBJECTIVES OF THE STUDY:

1) To examine the Health Care Facilities and Infrastructure in place to manage health services at district, block and village level.

2) To study the peculiar Health Care Problems & Challenges confronted in the rural areas of Himachal Pradesh.

3) To examine the Role and Effectiveness of Panchayati Raj Institutions in managing local health facilities.

4) To know the Peoples' Perception on Health Care Services and their views on different Medical and Health Institutions situated on their areas.

5) To evaluate the performance of Health Care Services Plan & Programmes.

HYPOTHESES:

In the present study following hypothesis have been formulated which will be tested:

1) There is positive correlation between Health Care Facilities and Infrastructure in rural areas of Himachal Pradesh.

2) People participation and role of Panchayati Raj Institutions is positively correlation in managing of Health Care System at Local Level.

THE STUDY AREA:

In Himachal Pradesh there are 12 districts viz. Bilaspur, Chamba, Hamirpur, Kangra, Kinnaur, Lahul-Spiti, Mandi, Shimla, Sirmour, Solan and Una. Out of these 12 districts, two districts Chamba and Kangra will be selected because of:

- Chamba: wholly mountainous and hard geographical area. Low literacy rate, low health facility and insufficient rural road connectivity.
- Kangra: plain area, highest population, sufficient road facility and health facility, multi super specialist hospital.

RESEARCH METHODOLOGY:

Present research is analytical and exploratory, so in order to achieve above mention objectives of the present study both primary and secondary data will be used.

Primary Data:

The present study will be largely based on primary data which will be collected through following instruments of data collection.

Questionnaire:

The rigorous questionnaire will be developed in the light of objectives of the present study.

Interview Schedules:

Information will also be collected through interview with the personnel who served there.

Observation:

Information gaps, if any will be redressed through personal observation.

Secondary Data:

The secondary data will be collected from the following sources:

- ❖ Journals and Articles.
- ❖ Published Books.
- ❖ Websites.

In addition secondary data will also be collected from:

- ❖ Department of Health and Family Welfare in Himachal Pradesh.
- ❖ Official Records.
- ❖ Census 2011.
- ❖ Ministry of Health and Family Welfare, etc.,

SAMPLE:

Keeping in view the need of adequacy and representativeness of sample Multistage Random Sample technique will be used. The Census of India 2011 will be the sample frame for this research work. In first phase of sample three blocks will be selected randomly from each district that i.e., Chamba and Kangra of the Himachal Pradesh. In the second phase of four panchayats from each block will be selected randomly. In third phase ten households (Head of the Family/any family member) from each panchayat will be selected randomly to know their view points.

Second sample will be drawn to seek information from Elected Panchayat Members to know their involvement in managing local health facilities.

Third sample will be drawn to seek information from medical and paramedical personnel working in the hospital/ dispensary situated in the study areas.

For proposed study 240 households, 120 elected panchayat members and medical personnel of each rank will be selected randomly as a sample.

TOOLS AND TECHNIQUES OF DATA ANALYSIS:

Consistent with the objectives of the study, different statistical techniques will be used for the analysis of the data collected will be placed in the tabular form. Different mathematical as well as statistical tools will be applied to analyze the relevant data. Simple arithmetical methods like; percentages, simple growth, compound growth and average growth will be applied along with the statistical techniques like arithmetic mean, standard deviation, co-efficient of co-relation.

PLAN OF CHAPTERS:

1) Introduction.

2) Health Care Facilities and Infrastructure.

3) Rural Health Care System: Problems and Challenges.

4) Involvement of PRI’s and People’s Participation.

5) Evaluation of Health Care Services.

6) Conclusions and Suggestions.

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